

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155228	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00198055 and Complaint IN00199001.</p> <p>Complaint IN00198055 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00199001 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated citations are cited.</p> <p>Survey dates: April 26, 27, 28 and 29, 2016</p> <p>Facility number: 000133 Provider number: 155228 AIM number: 100266080</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 6 Medicaid: 43 Other: 18 Total: 67</p>	F 0000	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>Please accept this Plan of Correction as Credible Allegations of Compliance. We respectfully ask for paper compliance on these issues.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0241 SS=D Bldg. 00	<p>Sample: 9</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on May 9, 2016</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who wanders throughout the facility and into other residents' rooms does not violate the other residents' dignity regarding private space and property for 1 of 1 residents reviewed for wandering in a sample of 9. (Resident #E, #J and #K)</p> <p>Findings include:</p> <p>Resident #K's clinical record was reviewed on 4-29-16 at 9:25 a.m. Her diagnoses included, but are not limited to, dementia without behavioral</p>	F 0241	<p>F241-Dignity and Respect of Individuality</p> <p>It has been and will continue to be the policy of this facility to promote the care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>	05/20/2016

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	<p>disturbances. Her most recent Minimum Data Set (MDS) assessment, dated 3-15-16, indicated she is significant cognitively impaired, but seems to understand what is spoken to her and is able to be understood by others. It indicated she wanders 4-6 days per week with no impact to others. It indicated she displays inattention and disorganized thinking on a fluctuating basis.</p> <p>In observation of Resident #K, she was observed to be able to self-propel herself throughout the facility's two wings without difficulty for the duration of the survey. On 4-26-16, between 9:40 a.m. and 9:52 a.m., during the initial tour of the facility with the Director of Nursing (DON), Resident #K was observed in her wheelchair on the opposite wing from which she resides near the nurse's station. On 4-27-16 at 11:00 a.m., she was seated in her wheelchair near the dining room and appeared to be observing staff and other residents. On 4-27-16 at 2:25 p.m., Resident #K was observed seated in her wheelchair near the west nurse's station, located on the opposite wing from which she resides, and appeared to be observing staff and other residents. On 4-28-16 at 10:30 a.m., Resident #K was observed in her wheelchair, participating in an activities program in the dining room. On 4-29-16 at 5:00 a.m., Resident #K</p>		<p>Prior to the date of this complaint the facility had advised Resident # E that the facility would provide her with a child safety device, that she had requested, for her door to help prevent any unwanted intrusions and Resident # E was satisfied with this. Child safety device is now in place and Resident # E is content.</p> <p>All residents have the potential to be affected. All cognitively intact residents were interviewed for any potential violations of their dignity and respect of individuality. No other concerns were noted at this time.(See attachment 4)</p> <p>Inservicing of all staff on the importance of promoting dignity and respect of individuality was performed on 5/11/16. Staff was reminded of the importance</p>		

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	<p>was observed seated in her wheelchair in the dining room, observing other residents and one dietary staff member in the dining room. On 4-29-16 at 10:35 a.m., Resident #K was observed seated in her wheelchair in the dining room, participating in an activities program. On 4-29-16 at 11:30 a.m., Resident #K was observed seated in her wheelchair in the hallway, near the dining room.</p> <p>In interview with the DON on 4-28-16 at 2:35 p.m., she indicated Resident #K "tends to wander all over." She indicated Resident #E has expressed being "very upset" with Resident #K for wandering into her room. She indicated the facility has placed stop signs at the doors of the rooms in which Resident #K tends to wander into. On 4-29-16 at 11:15 a.m., an observation of the facility indicated four resident rooms had "stop signs" at their doorways, with two of the four of the signs being strung across the entries to the resident rooms.</p> <p>In interview with the Social Services Designee (SSD) on 4-29-16 at 10:10 a.m., she indicated the facility has attempted several interventions in order to decrease the distress to other residents, caused by Resident #K wandering into their rooms. She specified, stop signs were placed to the doors of the rooms she</p>		<p>to address any issues with management to help solve issues.(See Attachment 5)</p> <p>IDT team will monitor residents for any adverse effects of resident interaction. This monitoring will take place five times weekly for two weeks, twice weekly for four weeks, and weekly for three months. Staff will interview two residents each hallway per session. (See attachment 1).</p> <p>Any issues will be brought to morning IDT meeting and appropriate measures will be put in place to rectify the situation.(See Attachment 2)</p> <p>Date of Completion: 5/23/16</p>	

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	<p>tends to wander into, staff redirection of Resident #K, including her in as many activities as possible, adding non-certified staff, identified as "Helping Hands," to spend as much time as possible with the resident and the use of "Activity Boxes." She indicated she has only received one grievance from any of the residents, from Resident #E, regarding being upset about Resident #K wandering into her room. The SSD provided a copy of a behavior tracking form. It indicated the behavior being monitored was the resident wandering into other residents's rooms. It had one entry, documented as occurring on 4-26-16. A handwritten note on the form indicated this tracking went into effect on 4-27-16, when she had become aware of an occurrence on 4-26-16. The SSD indicated she had spoken with Resident #K's daughter recently in regards to the resident's safety. She indicated the daughter told her she felt comfortable with Resident #K being at the facility and had no concerns regarding possible resident to resident abuse.</p> <p>In interview with Resident #E on 4-27-16 at 11:45 a.m., she indicated she has addressed her concerns with the Administrator regarding Resident #K wandering into her room. She indicated in the previous week, she counted 14</p>			

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	<p>times in which the resident wandered into her room, as well as that morning at 5:00 a.m. and again at 5:30 a.m. She indicated the facility has placed a "stop sign" across her door, but Resident #K will simply remove it, and on at least one occasion had taken it with her. She indicated she will tell Resident #K she is in the wrong room and the resident "always seems so confused about it."</p> <p>Review of Resident #E's clinical record on 4-29-16 at 9:15 a.m., indicated her diagnoses included, but were not limited to, unspecified PTSD (posttraumatic stress disorder). Her most recent Minimum Data Set (MDS) assessment, dated 3-19-16, indicated she is cognitively intact.</p> <p>In interview with Resident #J on 4-29-16 at 10:32 a.m., she indicated Resident #K will enter her room and "looks around, hasn't touched anything or taken [anything]. Made me feel like I had to put several of my knick-knacks away...Makes me feel uncomfortable." She indicated the facility placed a "stop sign" across her door, but it "doesn't slow her down. She moves it and comes in and has even taken it with her." She indicated she addressed her concerns regarding Resident #K's wandering into her room and that is how she received the</p>			

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	<p>"stop sign."</p> <p>Review of Resident #J's clinical record on 4-29-16 at 11:35 a.m., indicated her diagnoses included, but were not limited to, depression and chronic pain. Her most recent MDS assessment, dated 2-3-16, indicated she is cognitively intact.</p> <p>In interview with CNA #1 on 4-29-16 at 5:15 a.m., she indicated Resident #K "likes to wander...she calls it shopping and will wander into residents' rooms and pick up things. It upsets some of our residents. She is easily redirectable, but still can be upsetting to there residents that have their things touched or taken. She willingly will give back things."</p> <p>In interview with CNA #2 on 4-29-16 at 5:25 a.m., she indicated Resident #K "is blissfully unaware and always happy...She will sometimes wander into other residents's rooms and rummage through their things. We try to keep a close eye on her, but she's pretty fast in her wheelchair. It does seem to upset some of the residents when they have her come into their rooms."</p> <p>In interview with CNA #3 on 4-29-16 at 6:00 a.m., she indicated Resident #K tends to wander all over the facility in her wheelchair "and rummages through</p>			

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	<p>things. Sometimes, she will go into other peoples' rooms. We try to keep a close eye on her."</p> <p>In interview with RN #4 on 4-29-16 at 6:35 a.m., she indicated Resident #K "kind of roams the halls" in her wheelchair. She indicated, "Most of the other residents seem to understand she can't remember much of anything...[name of Resident #E] gets upset with her wandering around...[name of Resident #K] will occasionally wander into other residents' rooms and that will bother a few people [residents]. I can understand being upset with someone looking or touching your things."</p> <p>In interview with CNA #5 on 4-29-16 at 8:10 a.m., she indicated Resident #K "tends to wander the building and will go into other residents' rooms and this does upset some of the residents because they think she understands what she is doing and does this to be spiteful."</p> <p>Review of the nursing progress notes for April 1-29, 2016, failed to indicate any documentation of Resident #K's wandering. A "Care Plan Meeting" notation, dated 4-26-16 at 11:23 a.m., indicated a phone conference with the daughter had been conducted. A notation indicated, "There are no issues or</p>			

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F 0248 SS=D Bldg. 00	<p>concerns at this time."</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who has a history of wandering and intrusive behaviors into other residents' rooms has been continually assessed, care planned and appropriate interventions put into place for these behaviors to meet the needs of the resident for 1 of 1 residents reviewed for wandering in a sample of 9. (Resident #K)</p> <p>Findings include:</p> <p>Resident #K's clinical record was reviewed on 4-29-16 at 9:25 a.m. Her diagnoses included, but are not limited to, dementia without behavioral disturbances. Her most recent Minimum Data Set (MDS) assessment, dated 3-15-16, indicated she is significant</p>	F 0248	<p>F248-Activities Meet Interests/Needs of Each Resident</p> <p>It has been and will continue to be the policy of this facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Resident #K was placed on 1</p>	05/23/2016

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	<p>cognitively impaired, but seems to understand what is spoken to her and is able to be understood by others. It indicated she wanders 4-6 days per week with no impact to others. It indicated she displays inattention and disorganized thinking on a fluctuating basis.</p> <p>In observation of Resident #K, she was observed to be able to self-propel herself throughout the facility's two wings without difficulty for the duration of the survey. On 4-26-16, between 9:40 a.m. and 9:52 a.m., during the initial tour of the facility with the Director of Nursing (DON), Resident #K was observed in her wheelchair on the opposite wing from which she resides near the nurse's station. On 4-27-16 at 11:00 a.m., she was seated in her wheelchair near the dining room and appeared to be observing staff and other residents. On 4-27-16 at 2:25 p.m., Resident #K was observed seated in her wheelchair near the west nurse's station, located on the opposite wing from which she resides, and appeared to be observing staff and other residents. On 4-28-16 at 10:30 a.m., Resident #K was observed in her wheelchair, participating in an activities program in the dining room. On 4-29-16 at 5:00 a.m., Resident #K was observed seated in her wheelchair in the dining room, observing other residents and one dietary staff member in</p>		<p>on 1 activities no less than three times per week. Care plans were updated. An activity blanket was ordered for Resident #K. Resident #K will be brought down or encouraged to attend all activities she is able. Management staff, helping hands, or other direct care staff will continue to assist with Resident #K when other activities don't interest her.</p> <p>All other residents have the potential to be affected, but no other residents were affected. Care plans were reviewed and updated.</p> <p>Staff inservicing was done on 5/11/16 addressing the importance of activities.(See Attachment 5)</p> <p>Activity Director will monitor 1 on 1 activity log to make sure Resident #K is</p>	

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	<p>the dining room. On 4-29-16 at 10:35 a.m., Resident #K was observed seated in her wheelchair in the dining room, participating in an activities program. On 4-29-16 at 11:30 a.m., Resident #K was observed seated in her wheelchair in the hallway, near the dining room.</p> <p>In interview with the DON on 4-28-16 at 2:35 p.m., she indicated Resident #K "tends to wander all over." She indicated Resident #E has expressed being "very upset" with Resident #K for wandering into her room. She indicated the facility has placed stop signs at the doors of the rooms in which Resident #K tends to wander into. On 4-29-16 at 11:15 a.m., an observation of the facility indicated four resident rooms had "stop signs" at their doorways, with 2 of the signs being strung across the entries to the resident rooms.</p> <p>In interview with the Social Services Designee (SSD) on 4-29-16 at 10:10 a.m., she indicated the facility has attempted several interventions in order to decrease the distress to other residents, caused by Resident #K wandering into their rooms. She indicated interventions such as, stop signs to the doors of the rooms she tends to wander into, staff redirection of Resident #K, including her in as many activities as possible, adding</p>		<p>participating in activities, this monitoring will be done weekly for the next six weeks, biweekly for six weeks, and ongoing after.(See Attachment 3) Any failure to have her participating as necessary will be brought to IDT team for appropriate steps to be taken.</p> <p>IDT team will monitor residents for any adverse effects of resident interaction. This monitoring will take place five times weekly for two weeks, twice weekly for four weeks, and weekly for three months. Staff will interview two residents each hallway per session. (See attachment 1).</p> <p>Any issues will be brought to morning IDT meeting and appropriate measures will be put in place to rectify the situation.</p> <p>Date of Completion: 5/23/16</p>		

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	<p>non-certified staff, identified as "Helping Hands," to spend as much time as possible with the resident and the use of "Activity Boxes" have been utilized. She indicated she has only received one grievance from any of the residents, from Resident #E, regarding being upset about Resident #K wandering into her room. The SSD provided a copy of a behavior tracking form. It indicated the behavior being monitored was the resident wandering into other residents's rooms. It had one entry, documented as occurring on 4-26-16. A handwritten note on the form indicated this tracking went into effect on 4-27-16, when she had become aware of an occurrence on 4-26-16. The SSD indicated she had spoken with Resident #K's daughter recently in regards to the resident's safety. She indicated the daughter told her she felt comfortable with Resident #K being at the facility and had no concerns regarding possible resident to resident abuse.</p> <p>In interview with Resident #E on 4-27-16 at 11:45 a.m., she indicated she has addressed her concerns with the Administrator regarding Resident #K wandering into her room. She indicated in the previous week, she counted 14 times in which the resident wandered into her room, as well as that morning at 5:00</p>			

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	<p>a.m. and again at 5:30 a.m. She indicated the facility has placed a "stop sign" across her door, but Resident #K will simply remove it, and on at least one occasion had taken it with her. She indicated she will tell Resident #K she is in the wrong room and the resident "always seems so confused about it."</p> <p>In interview with Resident #J on 4-29-16 at 10:32 a.m., she indicated Resident #K will enter her room and "looks around, hasn't touched anything or taken [anything]. Made me feel like I had to put several of my knick-knacks away...Makes me feel uncomfortable." She indicated the facility placed a "stop sign" across her door, but it "doesn't slow her down. She moves it and comes in and has even taken it with her." She indicated she addressed her concerns regarding Resident #K's wandering into her room and that is how she received the "stop sign."</p> <p>In interview with CNA #1 on 4-29-16 at 5:15 a.m., she indicated Resident #K "likes to wander...she calls it shopping and will wander into residents' rooms and pick up things. It upsets some of our residents. She is easily redirectable, but still can be upsetting to there residents that have their things touched or taken. She willingly will give back things."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155228	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 2070 CHESTER BLVD RICHMOND, IN 47374
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	<p>In interview with CNA #2 on 4-29-16 at 5:25 a.m., she indicated Resident #K "is blissfully unaware and always happy...She will sometimes wander into other residents's rooms and rummage through their things. We try to keep a close eye on her, but she's pretty fast in her wheelchair. It does seem to upset some of the residents when they have her come into their rooms."</p> <p>In interview with CNA #3 on 4-29-16 at 6:00 a.m., she indicated Resident #K tends to wander all over the facility in her wheelchair "and rummages through things. Sometimes, she will go into other peoples' rooms. We try to keep a close eye on her."</p> <p>In interview with RN #4 on 4-29-16 at 6:35 a.m., she indicated Resident #K "kind of roams the halls" in her wheelchair. She indicated, "Most of the other residents seem to understand she can't remember much of anything...[name of Resident #E] gets upset with her wandering around...[name of Resident #K] will occasionally wander into other residents' rooms and that will bother a few people [residents]. I can understand being upset with someone looking or touching your things."</p>			

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	<p>In interview with CNA #5 on 4-29-16 at 8:10 a.m., she indicated Resident #K "tends to wander the building and will go into other residents' rooms and this does upset some of the residents because they think she understands what she is doing and does this to be spiteful."</p> <p>Review of the nursing progress notes for April 1-29, 2016 failed to indicate any documentation of Resident #K's wandering. A "Care Plan Meeting" notation, dated 4-26-16 at 11:23 a.m., indicated a phone conference with the daughter had been conducted. A notation indicated, "There are no issues or concerns at this time."</p> <p>3.1-33(a)</p>			